Department of Veterans Affairs

**Veterans Health Care System of the Ozarks**
**Fayetteville, Arkansas**

# Donations Form

___ Cash / Check ___ Non-Cash Date:

## Donor Information

Donated by: (Please circle one) Organization/Post/Chapter Individual

Organization/Individual's Name: _____
(Please Print)

Mailing Address: _____

City/State/Zip: _____

Person Delivering Item: _____

Designated Use of Cash Donation: _____

_____
(Please Print)

## Donation Information

| Please list - give a brief description | Estimated value |
|---|---|
| | |
| | |
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| | |

FOR OFFICE USE ONLY

Donor ID: _____ TY: _____ Sent: _____

Amount: _____ Check #_____ Check Date_____